Mount Sinai Fertility
Sinai Health System
250 Dundas Street West, Suite 700
Toronto Ontario M5T 2Z5

Clearly Imprint Patient Identification

Patient Consent for Email Communications

I, _____ (*name of Patient/Substitute Decision Maker*) wish to communicate with my care provider through email. I acknowledge and understand that these email messages are not encrypted on the hospital email system, and, therefore, the hospital cannot guarantee the security of messages that I send to or receive from my care provider.

I agree not to use email to communicate emergency or urgent health matters since email messages can be delayed for technical reasons beyond the control of my care provider. I understand my care provider may make decisions about my treatment based on information I provide through email and that this information will also form part of my health record if it is relevant to my care.

I acknowledge that at anytime, I or my care provider can decide that we no longer wish to communicate through email. If I decide to stop communicating through email, I agree to inform my care provider in writing or at my next appointment. If my care provider cannot continue email communications with me; he or she will inform me in writing and/or notify me about this at the time of my next appointment.

By signing this Consent, I confirm I have read and agree to these terms.

_____
Date Signed (YYYY MM DD)

_____ _____
Name of Patient/Substitute Decision Maker | Signature of Patient/Substitute Decision Maker

_____ _____
Name of Care Provider (please print) | Signature of Care Provider

_____ _____
Name of Translator (if required) | Signature of Translator (if required)